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**ATTACHMENT 4.19-B
METHODS AND STANDARDS
FOR
ESTABLISHING PAYMENT RATES
FOR
STATE PLAN COVERED SERVICES**

- A. When services which are reimbursed per a fee schedule, unless otherwise noted below, the same fee schedule applies to all providers -- both public and private -- and the fee schedule is published at the Iowa Medicaid Agency's website at: <https://dhs.iowa.gov/ime/providers/csrp/fee-schedule>.

Except for Other Independent Laboratory services and anesthesia services, the agency's rates were set as of July 1, 2017, and are effective for services on or after that date.

The fee schedule amounts for Other Independent Laboratory services, including code series 81000 are based on 95% of the Medicare Clinical Laboratory Fee Schedule. Effective January 1, 2017, and thereafter, the Department shall update the Independent Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

Effective July 1, 2017, the Department shall update the anesthesia conversion factor using the most current calendar update of the Medicare anesthesia conversion factor, adjusted for the state, converted to a per minute amount.

- B. The principles and standards established in OMB Circular A-87 are applied, when applicable, in determining rates regardless of the reimbursement methodology or fee schedule described below.
- C. Rates paid for individual practitioner services based on the fee schedule or methodology described below shall not exceed the provider's customary charges for the service billed. In order for the Iowa Medicaid Agency to meet the requirements of 42 CFR 447.203(b)(1) providers of individual practitioner services must bill Medicaid the customary charge for the service provided.
- D. Providers of services must accept reimbursement based upon the Iowa Medicaid agency fee or methodology without making any additional charge to the recipient.
- E. All payments are made to providers. The term "provider" means an individual or an entity furnishing Medicaid services under an agreement with the Iowa Medicaid agency. An entity need not be a facility such as a hospital, ICF/ID, or nursing. Pursuant to 42 CFR 447.15 (g), the term may include facilities or entities who employ or contract with persons who are authorized under the Iowa State Plan to provide covered services. Also an entity may provide, for example, "clinic services (as defined in 42 CFR 440.90)" or "home health services (as defined in 42 CFR 440.70) and other services which are otherwise covered under Iowa Medicaid through its employees or contractors. In the latter case the entity would also be paid for those non-clinic and

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or non-home health services if it had an employment contract or other contract with the licensed health care professional providing those services which meets the requirements of 42 CFR 447.15(g).

- F. Below is a description of the methods and standards for establishing rates for all covered services other than waiver services. The numbering and description of is identical to the list of covered services contained in ATTACHMENT 3.1-A. (Continued on page 2 of Att. 4.19-B)

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The following services will be modified:

Various services applicable to fees schedule language on page 1 (Physician Services; Podiatrist Services; Optometrist Services; Chiropractor Services; Audiology Services; Hearing Aide Dispenser Services; Psychologist Services; Services of Advanced Registered Nurse Practitioners; Services of Certified Nurse Anesthetists; Certain Pharmacists Services; Services of Advanced Nurse Practitioners Certified in Psychiatric or Mental Health Specialties; Renal Dialysis Clinics; Ambulatory Surgical Centers; Maternal Health Centers; Home Health-Medical Supplies and Equipment; Physical Therapy Services; Occupational Therapy Services; Services for Individuals with Speech, Hearing and Language Disorders; Prosthetic Devices; Eyeglasses; Nurse Midwife Services; Extended Services for Pregnant Women; Ambulatory Prenatal Care for Pregnant Women during a Presumptive Eligibility Period; Nurse Practitioner Services; Transportation Services) – Effective for services rendered on or after September 1, 2011, reimbursement will be 95% of the agency's rates set as of July 1, 2008, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 1 of Attachment 4.19-B)

Ambulance Services – Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 10%. Effective for services rendered on or after July 1, 2014, reimbursement rates will be increased by 10%. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered between December 1, 2009 and December 31, 2009, reimbursement will be made at 95% of Medicare's January 1, 2009 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered on or after January 1, 2010, reimbursement will be 95% of Medicare's January 1, 2010 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Various services applicable to fees schedule language on page 1 (Dental Services; Dentures; Medical and Surgical Services Furnished by a Dentist) – Effective for services rendered on or after December 1, 2009, reimbursement will be 97.5% of the agency's rates set as of July 1, 2008. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

Preventative Exam Codes rendered in connection to services provided by IowaCare network providers – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

EPSDT: Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 5 of Attachment 4.19-B)

Family Planning Services – Agency's rates were set as of July 1, 2008, and are effective for services rendered on or after that date. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

Existing IowaCare plan ended on December 31, 2013.

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Home Health-Intermittent Nursing Services – Effective for services rendered on or after December 1, 2009, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation. (Page 8 of Attachment 4.19-B)

Effective for services rendered on or after July 1, 2012, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at June 30, 2012, plus two percent; or the base year Medicare per visit limitations plus inflation (Page 8 of Attachment 4.19-B).

Community Mental Health Centers – Effective for services rendered December 1, 2009 through June 30, 2010, reimbursement will be reduced to 97.5% of reconciled cost. (Page 9, of Attachment 4.19-B)

Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 12 of Attachment 4.19-B)

Hospital-Specific Base APC Rates – Effective for services rendered on or after December 1, 2009, all reimbursement rates will be reduced by 5%, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 14 of Supplement 2 of Attachment 4.19-B)

Graduate Medical Education and Disproportionate Share Pool – Effective from December 1, 2009, the total annual pool amount that is allocated to the Graduate Medical education and disproportionate share pool for direct medical education related to outpatient services is \$2,776,336. (Page 22 of Supplement 2 of Attachment 4.19-B).

Physician and Non-Physician Care Services Rendered in Facility Settings – Effective for services rendered on or after July 1, 2017, physician and non-physician care providers are subject to a site-of-service payment adjustment. A site of service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Iowa Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service. The Department shall update the Medicare differentials applied to the site-of-service payment adjustment every January 1, thereafter.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician and non-physician care services. The agency's rate was set as of July 1, 2017, and is effective for services provided on or after that date. All rates are published on the agency's website: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>.

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Physician-Administered Drugs – Effective for services rendered on or after September 1, 2012, reimbursement for HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999, will be reduced by 2%. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:

http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

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limits on amount, duration and scope contained in SUPPLEMENT 2 TO ATTACHMENT 3.1-A.

1. INPATIENT HOSPITAL SERVICES

See Attachment 4.19 - A of the State Plan

2a. OUTPATIENT HOSPITAL SERVICES

See Supplement 2 to Attachment 4.19-B of the State Plan

2b. RURAL HEALTH CLINICS SERVICES

X The payment methodology for rural health clinics will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

— The payment methodology for rural health clinics will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for rural health clinics will conform to BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

- 1) is agreed to by the State and the clinic; and
- 2) results in payment to the clinic of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement

The APM reimbursement methodology for rural health clinics is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement

The Department uses the clinic's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost. Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the rural health clinic. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate, which would be paid to participating rural health clinics under the prospective payment system considering any change in the scope of service applying all appropriate Medicare Economic Index increases. The Department will compute the center's FY 1999 and FY 2000 per visit rate for each clinic and will use an average of the two as the initial PPS base rate. This rate will be used to calculate the total

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payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each clinic an encounter rate that is at least equal to the PPS rate specific to each clinic. The clinic must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Clinics

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

- ☒ The payment methodology for federally qualifying health centers will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.
- ☐ The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements Prospective Payment System.
- ☒ The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:
 - 1) is agreed to by the State and the center; and
 - 2) results in payment to the center of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement

The APM reimbursement methodology for federally qualified health centers is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement

The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost.

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Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the federally qualified health center. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate which would be paid to participating federally qualified health centers under the prospective payment system, considering any change in the scope of service and applying all appropriate Medicare Economic Index increases. This rate will be used to calculate the total payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each center an encounter rate that is at least equal to the PPS rate specific to each clinic. The center must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Centers

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

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3. OTHER INDEPENDENT LABORATORIES SERVICES

Fee Schedule. The fee schedule is 95.00% of the Medicare Clinical Laboratory Fee Schedule.

4a. NURSING FACILITY SERVICES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES)

See Attachment 4.19-D of the State Plan.

4b. EARLY PERIODIC DIAGNOSTIC AND SCREENING SERVICES

- (1) Outpatient Hospital Services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (2) Services of licensed practitioners of the healing arts: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (3) Private duty nursing services: For services on or after, July 1, 2013, payment for private duty nursing services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per hour. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.
- (4) Home health services –medical supplies and equipment: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (5) Personal care services: For services on or after, July 1, 2013, payment for personal care services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per 15 minutes. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.
- (6) Dental services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (7) Diagnostic services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (7a) Preventive Services: Fee Schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of July 1, 2014, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.
- (8) Rehabilitative Services: For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using finalized cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov. Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

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(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

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For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

- (9) Transportation services: Fee schedule.

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(10) Personal care services: Same basis as home health services – home health aide described in Item 7b.

4c. FAMILY PLANNING SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

4d. TOBACCO CESSATION SERVICES

Fee Schedule. To maximize the effectiveness of tobacco cessation medications, counseling services are available for Medicaid member use in conjunction with cessation medication. Counseling services must be prescribed by a licensed practitioner participating in the Iowa Medicaid Program. Clinicians and other licensed practitioners must bill their usual and customary charges and must use the appropriate CPT codes to bill for counseling services.

5a. PHYSICIANS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

5b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6a. PODIATRISTS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6b. OPTOMETRISTS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6c. CHIROPRACTORS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d1. RESERVED

6d2. RESERVED

6d3. AUDIOLOGY SERVICES

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Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d4. HEARING AID DISPENSER SERVICES

Fee schedule. The fee schedule is based on the definitions of medical and surgical supplies given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

6d5A. PSYCHOLOGISTS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d5B. SOCIAL WORKERS' SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The following are exceptions:

When social worker services are provided by a social worker employed by a physician, hospital, home health agency, rural health clinic, federally qualified health center or community mental health center, payment for the service will be made to the provider based upon a fee schedule for physician and community mental health center and the reimbursement defined for hospital, home health agency, rural health clinic and federally qualified health center services.

6d6 BEHAVIORAL SCIENCE PRACTITIONERS

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d7 RESERVED

6d8 A. SERVICES OF ADVANCED REGISTERED NURSE PRACTITIONERS

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

6d8 B. SERVICES OF CERTIFIED NURSE ANESTHETISTS

Fee Schedule. Payment for CRNA services is made using the CMS fee schedule (CPT-4) anesthesiology procedure list and associated base units. When the CRNA receives medical direction from the surgeon, reimbursement to the CRNA is 80% of the amount that would be paid to an anesthesiologist (MD or DO). When the CRNA receives medical direction from an anesthesiologist, reimbursement to the CRNA is 60% of what an anesthesiologist would receive for the same procedure.

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6d9. CERTAIN PHARMACISTS SERVICES: Fee schedule.

6d10. SERVICES OF ADVANCED NURSE PRACTITIONERS CERTIFIED IN PSYCHIATRIC OR MENTAL HEALTH SPECIALTIES: Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

7. HOME HEALTH SERVICES – SKILLED NURSING SERVICES, HOME HEALTH AIDE SERVICES, PHYSICAL THERAPY SERVICES, OCCUPATIONAL THERAPY SERVICES & SPEECH PATHOLOGY SERVICES

The payment for each home health service is determined retrospectively based on the disciplines (skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), and speech therapy in aggregate. Interim payments for home health agencies are made based on the home health agency's cost-to-charge ratios. A tentative cost settlement is performed based on the as-submitted Medicare cost report and a final cost settlement is performed based on the finalized Medicare cost report.

For services on or after July 1, 2013, the payment for each home health service is determined by the Medicare low utilization payment adjustment (LUPA) wage index-adjusted fee schedule rates for each of the disciplines (skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), and speech therapy (ST). The LUPA base rates and the Medicare wage index shall be updated every two years.

For services on or after July 1, 2015, payment will be the most current Medicare LUPA rates less 8.35%.

For services on or after July 1, 2016, the Medicaid LUPA wage index-adjusted fee schedule rates in effect on June 30, 2016, will be increased by 2.93%.

For services on or after July 1, 2017, payment will be the most current Medicare LUPA rates less 19.18%.

7a. HOME HEALTH SERVICES - MEDICAL SUPPLIES AND EQUIPMENT: Fee schedule.

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8. RESERVED

9. CLINIC SERVICES

Physician and dental fee schedules, except as follows:

- (a). Clinics that are renal dialysis clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.
- (b). Clinics that are ambulatory surgical centers are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.
- (c). Clinics that are maternal health centers are paid for clinic services on a prospective cost-based fee schedule with no retroactive cost settlement, as determined by the Department based on a cost center report submitted by clinics on an annual basis. Services payable to the clinics include: 1) Maternal Health 2) Maternal Oral Health 3) Immunization 4) Laboratory. Cost of services to calculate the cost-based fee schedule rates includes direct cost (personnel and supplies) and overhead indirect cost incurred to support the services. Agency rates were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.
- (d). Clinics that are family planning clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.
- (e). Clinics that are operated by the United States Indian Health Service (IHS) or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," or "tribal organization," as those terms are defined in 25 USC 1603, are paid at the rate for outpatient medical care provided by IHS facilities that is published by IHS in the federal register each calendar year for Medicaid beneficiaries. For services provided, these clinics may bill for one visit per patient per calendar day for medical services (at the outpatient per visit rate (excluding Medicare)), which shall constitute payment in full for all services provided on that day, except as follows. For services provided, these clinics may bill for multiple visits per patient per calendar day for medical services (at the outpatient per visit

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rate (excluding Medicare)), only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services, dental services, mental health and addiction services, Early & Periodic Screening, Diagnostic, and Treatment services for children and other outpatient services. A visit is a face-to-face contact between a patient and a health professional at the clinic.

For services provided, these clinics may bill for one visit per patient per calendar day for covered outpatient prescribed drugs provided by the facility (at the outpatient prescribed drugs per visit rate (excluding Medicare)), which shall constitute payment in full for all services provided on that day.

(f). When a facility provides services, which are otherwise covered under the state plan, in addition to clinic services, payment is based on the methodology as defined for the service that is provided.

(g). Reimbursement methodology for Community Mental Health Centers:

Community Mental Health Centers may choose one of the following reimbursement methodologies:

1. Prospective statewide rate.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of

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community mental health services. The agency's fee schedule rate was set as of July 1, 2014 and is effective for services provided on or after that date.

All rates are published on the agency's website at:
http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

2. 100 percent of the reasonable costs of service.

This methodology will consist of a cost report and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Interim Payment

The Department makes interim payments to the Community Mental Health Center based upon 105% of the greater of the statewide fee schedule for Community Mental Health Centers effective July 1, 2006 or the average Medicaid managed care contracted fee amounts for Community Mental Health Centers effective July 1, 2006.

After cost reports are received, the Department will examine the cost data for Community Mental Health Center services to determine if an interim rate change is justified.

Determination of Medicaid-allowable direct and indirect costs

To determine the Medicaid-allowable direct and indirect costs of providing Community Mental Health Center services, the following steps are performed:

1. Direct costs for Community Mental Health Center services include unallocated payroll costs and other unallocated costs that can be directly assigned to Community Mental Health Center services. Direct payroll costs include total compensation of direct services personnel.

Other direct costs include costs directly related to the approved Community Mental Health Center personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment.

These direct costs are accumulated on the annual cost report, resulting in total direct costs.

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2. General and Administrative indirect costs are determined based on the percentage of directly assigned Community Mental Health Center direct cost to Total cost before general and administrative overhead.
3. Net direct cost and general and administrative indirect costs are combined.
4. The combined costs from Item 3 are divided by total Community Mental Health Center units of service provided for all patients to calculate a cost per unit.
5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the total Medicaid units of service that were paid from the claims data.

Annual Cost Report Process

Community Mental Health Centers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after their fiscal year for free-standing clinics and 120 days for hospital-based clinics. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Community Mental Health Center.

The primary purposes of the Medicaid cost report are to:

1. Document the provider's total Medicaid-allowable costs of delivering Medicaid coverable services.
2. Reconcile annual interim payments to its total Medicaid allowable costs.

All filed annual Medicaid cost reports are subject to a desk review by the Department or its designee. Community Mental Health Centers must eliminate unallowable expenses from the cost report. If they are not removed the Department or its designee will make the appropriate adjustments to the Community Mental Health Center's Medicaid cost report.

Cost Reconciliation Process

The cost reconciliation must be completed by the Department or its designee within twenty-four (24) months of the end of the cost reporting period covered by the annual Medicaid cost report. The total Medicaid-allowable costs are compared to interim payments received

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by the Community Mental Health Center for services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

Cost Settlement Process

EXAMPLE: For services delivered for the period January 1, 2010, through December 31, 2010, the annual Medicaid cost report is due on or before March 31, 2011, for free-standing clinics or May 31, 2011, for hospital-based clinics, with the cost reconciliation process completed no later than December 31, 2012.

If a Community Mental Health Center's payments for Medicaid-covered services exceed the actual Medicaid costs for services, the Department will recoup the overpayment using one of these two methods:

1. Offset all future claims payments from the Community Mental Health Center until the amount of the overpayment is recovered for a period not to exceed 12 months;
2. The Community Mental Health Center will return an amount equal to the overpayment to the US Department of Health and Human Services.

If a Community Mental Health Center's actual Medicaid costs exceed the payments for Medicaid-covered services the Department will pay the difference to the Community Mental Health Center.

The Department shall issue a notice of settlement that denotes the amount due to or from the Community Mental Health Center.

10. DENTAL SERVICES

Fee Schedule. The definitions of dental and surgical procedures are based on the definitions of dental and surgical procedures given in the Current Dental Terminology (CDT).

11a. PHYSICAL THERAPY SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

11b. OCCUPATIONAL THERAPY SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

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11c. SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent addition of Physician's Current Procedural Terminology (CPT).

12a. PRESCRIBED DRUGS

(a). Reimbursement for covered outpatient prescription and nonprescription drugs shall be the lowest of the following as of the date of dispensing:

1. "Actual Acquisition Cost" (AAC), defined as the average state AAC, as determined from biannual surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee pursuant to subsection (b). If no state AAC is available, the AAC will be defined as the Wholesale Acquisition Cost (WAC).
2. "Federal upper limit (FUL)," defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee pursuant to subsection (b).
3. Total submitted charge.
4. The provider's usual and customary charge to the general public.

(b). The professional dispensing fee is based on the cost of dispensing survey which must be completed by all medical assistance program participating pharmacies every two years beginning in 2014. For services rendered on or after August 1, 2016, the professional dispensing fee is \$10.02.

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(c). 340B Purchased Drugs - Reimbursement for a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), plus the professional dispensing fee pursuant to subsection (b).

(d). 340B Contract Pharmacies - Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

(e). Federal Supply Schedule (FSS) Drugs - Reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the provider's actual acquisition cost (not to exceed the FSS price), plus the professional dispensing fee pursuant to subsection (b).

(f). Nominal Price Drugs - Reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR § 447.508 will be the provider's actual acquisition cost (not to exceed the Nominal Price), plus the professional dispensing fee pursuant to subsection (b).

(g). Reimbursement for Specialty Drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail pharmacy shall be the lowest of the following as of the date of dispensing:

1. "Actual Acquisition Cost" (AAC), defined as the average state AAC, as determined from biannual surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee pursuant to subsection (b). If no state AAC is available, the AAC will be defined as the Wholesale Acquisition Cost (WAC).
2. "Federal upper limit (FUL)," defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee pursuant to subsection (b).
3. Total submitted charge.
4. The provider's usual and customary charge to the general public.

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(h). Reimbursement for drugs not dispensed by a retail community pharmacy (i.e., institutional or long term care pharmacy when not included as part of an inpatient stay) shall be the lowest of the following as of the date of dispensing:

1. "Actual Acquisition Cost" (AAC), defined as the average state AAC, as determined from biannual surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee pursuant to subsection (b). If no state AAC is available, the AAC will be defined as the Wholesale Acquisition Cost (WAC).
2. "Federal upper limit (FUL)," defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee pursuant to subsection (b).
3. Total submitted charge.
4. The provider's usual and customary charge to the general public.

(i). Reimbursement for clotting factor from specialty pharmacies, hemophilia treatment centers (HTCs) or Centers of Excellence shall be the lowest of the following as of the date of dispensing:

1. "Actual Acquisition Cost" (AAC), defined as the average state AAC, as determined from biannual surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee pursuant to subsection (b). If no state AAC is available, the AAC will be defined as the Wholesale Acquisition Cost (WAC).
2. "Federal upper limit (FUL)," defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee pursuant to subsection (b).
3. Total submitted charge.
4. The provider's usual and customary charge to the general public.

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(j). Reimbursement for physician administered drugs submitted under the medical benefit is set by a Fee Schedule, based on Average Wholesale Price (AWP) of the drug less 15.6 percent, which is based on the following formula:

1. Average of the Average Wholesale Price (AWP) for the applicable National Drug Codes (NDCs) less 12 percent
2. Amount calculated in (1) less 5 percent
3. Amount calculated in (2) plus 1 percent

Reimbursement for covered entities using drugs purchased through the 340B drug pricing program at the 340B covered entity actual acquisition cost (AAC).

(k). Reimbursement is not provided for investigational drugs, which are not covered.

(l). An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by a pharmacist.

(m). Reimbursement for drugs provided by Indian Health providers is at the rate for outpatient medical care provided by IHS facilities that is published by IHS in the federal register each calendar year for Medicaid beneficiaries. Indian Health providers may bill for one covered outpatient prescribed drug visit per patient per calendar day for covered outpatient prescribed drugs provided by the facility, which shall constitute payment in full for all drugs provided on that day, including reimbursement for dispensing fees, ingredient cost, and any necessary counseling. For this purpose, Indian Health providers are pharmacies operated by the United States Indian Health Service (IHS) or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," or "tribal organization," as those terms are defined in 25 USC 1603.

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Pharmacies and providers will submit information to the department or its designee within 30 days following a request for such information unless the department or its designee grants an extension upon written request of the pharmacy or provider. Pharmacies and providers are required to produce and submit information in the manner and format requested by the department or its designee, as requested, at no cost to the department or its designee.

12b. DENTURES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12c. PROSTHETIC DEVICES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12d. EYEGLASSES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES

For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1, 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

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13d. REHABILITATIVE SERVICES (Cont.)

For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

ACT Services. The state-wide fee amount is a daily rate of \$51.08 per client.

The fee is paid to the ACT team according to the number of days that the client has received ACT services.

The state-wide fee amount was established by Magellan based on a review of site budgets that included expenses for salaries, administrative costs, and other allowable costs as well as service costs. The reasonableness of cost was evaluated related to client to staff ratio. A ratio of 7 clients to 1 staff was used in the determination of the rate.

Each ACT team receiving payment under provisions of services as defined in Section 3.1A will be required to sign a contract enrolling in the Medicaid program and to file a report with the Medicaid agency annually.

This annual reporting would include at a minimum:

- ◆ Data, by practitioner, on the utilization by Medicaid beneficiaries of all the services included in the unit rate and;
- ◆ Cost information by practitioner type and by type of service actually delivered within the service unit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ACT services. The agency's fee schedule rate was set as of April 1, 2016 and is effective for services provided on or after that date. All rates are published at <https://secureapp.dhs.state.ia.us/MedicaidFeeSched/>

State Plan TN #	<u>IA-16-022</u>	Effective	<u>April 1, 2016</u>
Superseded TN #	<u>IA-07-013</u>	Approved	<u>July 22, 2016</u>

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Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.

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11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

For services provided prior to July 1, 2011, Rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary costs shall not exceed 110 percent of the statewide average allowable costs for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

14a. SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

See Attachment 4.19-A of the State Plan.

14b. SERVICES FOR INDIVIDUAL AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – NURSING FACILITY SERVICES

See Attachment 4.19-D of the State Plan.

15a. ICF/MR SERVICES – NOT PUBLIC

See Attachment 4.19-D of the State Plan.

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15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

16. INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 YEAR OF AGE

See Attachment 4.19-A of the State Plan.

17. NURSE-MIDWIFE SERVICES

When nurse midwife services are provided in a birthing center by a nurse-midwife employed by the center, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse mid-wives in birth centers, provided the nurse mid-wife is required to turn over his or her fees to the center as a condition of employment.

When nurse midwife services are provided in a birthing center by a nurse mid-wife with whom the nurse-midwife has a contract under which the facility submits the claim, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse midwives in birthing centers.

State Plan TN # MS-11-010Superseded TN # None

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All other payments for the services of an nurse-midwife enrolled in the Iowa Medicaid program shall be paid on the basis of the fee schedule for services provided nurse mid-wives and no separate payment shall be made to any other facility or provider in connection with the birth, other than a hospital, or ambulatory surgical center. The nurse-midwife fee schedule is based on 85% of the physician fee schedule.

18. HOSPICE SERVICES

Iowa Medicaid reimburses for hospice services in accordance with the requirements of Section 4306 of the State Medicaid Manual (Hospice Reimbursement).

Pursuant to Section 4307 of the State Medicaid Manual (Payment for Physician Services Under Hospice), when the Iowa Medicaid agency has been notified of the name of the physician who has been designated as the attending physician and is not a hospice employee, the Iowa Medicaid Agency will reimburse the attending physician in accordance with the physician fee schedule described in Item 5a.

19a. CASE MANAGEMENT SERVICES

For target group 1 (Adults with chronic mental illness, and severely emotionally disturbed children receiving services through the HCBS Children's Mental Health waiver); and target group 2 (Persons with a developmental disability, including mental retardation):

For the period of December 3, 2009, through June 30, 2010, case management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed using a monthly unit established on the basis of the provider's reasonable and necessary costs in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." A prospective cost-based interim rate will be set based on the finalized FYE June 30, 2009 financial and statistical cost report. An inflation factor of 4.8% will be applied from midpoint of the cost report period to midpoint of the rate period (January 1, 2009 through March 15, 2010), then reduced by 2.5% resulting in an inflation factor of 2.3%. If the provider's cost does not support the payments made during December 1, 2009, - June 30, 2010, the provider will be required to return the difference between actual cost and the prospective cost-based rate. If actual cost exceeds the prospective cost-based rate the amount paid to the provider shall be actual cost less 2.5% not to go lower than the prospective cost-based rate. Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

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For the period July 1, 2010, and thereafter, reimbursement rates for case management providers will be established on the basis of a 15 minutes unit in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." Case Management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency.

Interim Payment

The Department will make interim payments to Case Management providers based upon a projected cost report. Providers are required to submit a CMS-approved, Medicaid projected cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment.

Annual Cost Report Process

Case Management providers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after each fiscal year end. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Case Management.

The Medicaid cost report data includes direct costs, programmatic indirect costs, and general and administrative costs. Direct costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel and other direct costs related to the delivery of Case Management services. Programmatic indirect costs include salaries, benefits and other costs that are indirectly related to the delivery of Case Management services. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the Case Management service, constitute costs that support the operations of the Case Management agency. These general and administrative overhead costs are included in accordance with OMB Circular A-87.

Effective for services on or after July 1, 2013, programmatic indirect costs and general and administrative overhead costs are limited to 23 percent of total allowable direct costs.

Case Management providers must eliminate unallowable expenses from the cost report. If they are not removed Iowa Medicaid will make the appropriate adjustments to the Case Management's Medicaid cost report.

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Cost Reconciliation Process

The cost reconciliation must be completed within twenty-four (24) months of the end of the cost report period covered by the annual Medicaid cost report. The total Medicaid allowable costs per unit are compared to the interim projected rate paid for services delivered during the reporting period. Retroactive claim adjustments are made based on the final rates determined using the final actual financial reports.

Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

Target Group 3

For target group 3 (Children from birth to age three who meet the "developmental delay" eligibility categories set forth in the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA)):

Case management services are reimbursed according to a fee schedule, established September 1, 2002 and updated July 1, 2005 for services rendered on or after that date, based on 15-minute units of service. The number of 15-minute units billed cannot exceed 24 per day per case manager.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management for target group 3 and the fee schedule and any annual periodic adjustments to the fee schedule are published on the agency's website at:

www.ime.state.ia.us/Reports_Publications/FeeSchedule.html.

19b RESERVED

20. EXTENDED SERVICES FOR PREGNANT WOMEN
Fee Schedule.

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21. AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN DURING A PRESUMPTIVE ELIGIBILITY PERIOD
Fee Schedule.
22. RESERVED
23. NURSE PRACTITIONER SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is based on 85% of the physician fee schedule.
- 24a. TRANSPORTATION SERVICES
Fee Schedule. If transportation is by car, the maximum payment that may be made is the actual charge made by the provider for transportation to and from the source of medical care, based on a fee schedule.
- 24b. RESERVED
- 24c. RESERVED
- 24d. SKILLED NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE
See Attachment 4.19-D of the State Plan.
- 24e. RESERVED
- 24f. RESERVED
- 25g. RESERVED
26. RESERVED
27. RESERVED
28. RESERVED

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29. FREE-STANDING BIRTH CENTER SERVICES

Reimbursed based on a fee schedule as follows:

- (a) Payment for covered services provided by a participating free-standing birth center is limited to the lesser of the charges billed or the allowable rates per fee schedule.
- (b) The fee schedule established is based upon: (1) review of Medicaid fees paid by other states; (2) Medicaid fees for similar services; (3) Medicare fees; and/or (4) some combination or percentage thereof.

Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:

http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

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JUL - 2 2013

29. Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable ConditionsOther Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(B)

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable conditions identifies below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services) of the plan:

Medical claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (4) diagnoses codes on the claim.

TN No.

IA-11-018

Effective

SEP - 1 2011

Supersedes TN No.

NONE

Approved

MAY 25 2012

State/Territory:

IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care**Supplemental Payments for Physician and Professional Services at Qualifying Iowa State-Owned or Operated Professional Services Practices****1. Qualifying Criteria**

Physicians and other eligible professional service practitioners as specified in 2. below who are employed by, or under contract to, or who assigned Iowa Medicaid payments to an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency programs recognized by the American College of Graduate Medical Education (ACGME) may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

- a. licensed by the State of Iowa;
- b. enrolled as a Iowa Medicaid provider; and,
- c. identified by the Iowa state-owned hospital as a physician or professional service practitioner that is employed, under contract with, or provides services affiliated with the Iowa state-owned hospital.

Providers that qualify under this criterion are the following:

- The University of Iowa Hospitals and Clinics

2. Qualifying Providers Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

- a. Physicians;
- b. Physician Assistants;
- c. Advanced Registered Nurse Practitioners (ARNPs);
- d. Certified Registered Nurse Anesthetists (CRNAs);
- e. Certified Nurse Midwives (CNMs);
- f. Clinical Social Workers (CSWs); and
- g. Clinical Psychologists

3. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms "physician" and "physician services" includes services provided by all qualifying provider types as set forth in "2.", above.

State Plan TN #	IA-14-012	Effective	July 1, 2014
Superseded TN #	IA-06-003	Approved	June 24, 2015

State/Territory:

IOWA

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. For services provided by physicians at a hospital meeting the criteria as set forth in "1." above, the state will collect from the hospital its current commercial physician fees by CPT code for the hospital's top five commercial payers by volume.
- b. The state will calculate the average commercial fee for each CPT code for each qualifying provider type, as defined under "2." above, that provides services at, under contract to, or in affiliation with the Iowa state-owned hospital.
- c. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those qualifying provider types, as defined under "2." above, who will qualify for a supplemental payment. The state will align the average commercial fee for each CPT code as determined in "b." above to each Medicaid claim for each qualifying provider type, as defined under "2." above and calculate the average commercial payments for the claims.
- d. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for each qualifying provider type, as defined under "2." above and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
- e. The state will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three years.
- f. For each quarter the state will extract paid Medicaid claims for each qualifying provider type, as defined under "2." above for that quarter.
- g. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.
- h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the physician or physician practice plan for that quarter.

State Plan TN #	<u>IA-14-012</u>	Effective	<u>July 1, 2014</u>
Superseded TN #	<u>N/A - New Page</u>	Approved	<u>June 24, 2015</u>

State/Territory:

IOWA

4. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after July 1, 2014. This payment is based on the Medicare equivalent of the average commercial rate and is set using the calendar year 2013, Medicare physician fee schedule for hospital-based services rendered by the qualifying providers defined under "2." above. After the initial calculation for fiscal year 2014-2015, Iowa will rebase the Medicare equivalent of the average commercial rate using adjudicated claims data for dates of service from the most recently completed fiscal year. This calculation will be made every three years. A link to the Medicare fee schedule used to determine the payment factor will be posted on the Iowa Medicaid Enterprise (IME) website at www.ime.state.ia.us.

State Plan TN #	<u>IA-14-012</u>	Effective	<u>July 1, 2014</u>
Superseded TN #	<u>N/A – New Page</u>	Approved	<u>June 24, 2015</u>

State: Iowa
TN: IA-17-003

§1915(i) HCBS State Plan Services

Attachment 4.19-B

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Effective May 1, 2017

Approved: September 21, 2017

Supersedes: IA-16-009

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input checked="" type="checkbox"/>	<p>HCBS Case Management</p> <p>Providers of case management services shall be reimbursed at cost. Providers are reimbursed throughout each fiscal year on the basis of a projected interim payment rate for a 15-minute unit of service based on each provider's reasonable and proper costs of operation. Reasonable and proper costs of operation are identified pursuant to federally accepted reimbursement principles (OMB A-87 principles).</p> <p>The methodology for determining the reasonable and proper cost for service provision assumes the following:</p> <ul style="list-style-type: none"> • The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation. • Mileage shall be reimbursed at a rate no greater than the state employee rate. • Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A). <p>Interim payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664., Financial and Statistical Report submitted by providers ninety days after each fiscal year end. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost apportionment.</p>
<input checked="" type="checkbox"/>	<p>HCBS Home-Based Habilitation</p> <p>For services provided on July 1, 2013 through December 31, 2013, home-based habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.</p> <p>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of May 1, 2017 and is effective for services provided on or after that date.</p> <p>All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule</p>

State: Iowa
TN: IA-17-003

§1915(i) HCBS State Plan Services

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Effective May 1, 2017

Approved: September 21, 2017

Supersedes: IA-16-009

<input checked="" type="checkbox"/>	<p>HCBS Day Habilitation</p> <p>For services provided on July 1, 2013 through December 31, 2013, day habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.</p> <p>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of April 1, 2016 and is effective for services provided on or after that date.</p> <p>The rates for Day habilitation are located at 441 IAC 79.1(2) https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf</p>
<input type="checkbox"/>	<p>HCBS Behavioral Habilitation</p>
<input type="checkbox"/>	<p>HCBS Educational Services</p>
<input checked="" type="checkbox"/>	<p>HCBS Prevocational Habilitation</p> <p>For services provided on July 1, 2013 through December 31, 2013, prevocational habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.</p> <p>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of May 1, 2017 and is effective for services provided on or after that date.</p> <p>All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule</p>
<input checked="" type="checkbox"/>	<p>HCBS Supported Employment Habilitation</p> <p>For services provided on July 1, 2013 through December 31, 2013, supported employment habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fee schedule rate was set as of July 1, 2013 and is effective for dates of service provided on and after that date through December 31, 2013.</p> <p>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of May 1, 2017 and is effective for services provided on or after that date.</p> <p>All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule</p>

	Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) (*Select one*):

<input checked="" type="radio"/>	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
<input type="radio"/>	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined.
The presumptive period will be <input type="text"/> days (not to exceed 60 days).	

Effective: JUN 01 2008

Approved: AUG 01 2008

Supersedes: MS-07-001

	<p>Reimbursement for Supported Employment activities to obtain a job – job development, and supported employment activities to obtain a job – employer development is based on a fee schedule developed by the state Medicaid agency with advice and consultation from the appropriate professional group and reflects the amount of resources involved in service provision.</p> <p>Reimbursement for all other Supported Employment activities is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.</p>
<input type="checkbox"/>	Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) (*Select one*):

<input checked="" type="radio"/>	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
<input type="radio"/>	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined.
The presumptive period will be <input type="text"/> days (not to exceed 60 days).	

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

Description
Data Source
Frequency of Data Collection

ii. Emergency room visits

Description
Data Source
Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description
Data Source
Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

i. Hospital admission rates
Chronic disease management
iii. Coordination of care for individuals with chronic conditions
iv. Assessment of program implementation
Processes and lessons learned
vi. Assessment of quality improvements and clinical outcomes
vii. Estimates of cost savings

ii.

v.

4.19 - B: Payment Methodology View

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**Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy**

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type
Health Home Provider

Description

Overview of Payment Structure:
Iowa has developed the following payment structure for designated Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Iowa. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Patient Management Per Member Per Month Payment
This reimbursement model is designed to only fund Health Home services that are not covered by any of the currently available Medicaid funding mechanisms. Health Home Services, as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes. Iowa Medicaid Enterprise recognizes that health home transformation requires financial support to clinic leadership and administrative functions so that members receive services in a data driven, population focused, and person centered environment. The criteria required to receive a monthly PMPM payment is:
A. The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR).
B. The member has full Medicaid benefits at the time the PMPM payment is made.
C. The member has agreed and enrolled with the designated health home provider.
D. The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
E. The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring

Effective: 7-1-12 Approved: 6-7-12

for treatment gaps defined as Health Home Services in this State Plan, or a covered service defined in this state plan was provided that was documented in the member's EHR.
a. The health home will attest, by a monthly claim submission, that the minimum service requirement is met. The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of claim submission.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Tier Minutes Per Month Sum of Chronic Conditions

Tier 1 15 1-3
Tier 2 30 4-6
Tier 3 60 7-9
Tier 4 90 10 or more

Additional Tiering Information

Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

Reimbursement for Evaluation and Management (E/M) procedure code 99215 as of January 2012 was used as the base value for determining one hour of physician work. The count of major conditions serves as a proxy for the time (expressed in minutes in above table) and work required to coordinate patient care. PMPM time units of care coordination were determined for each tier utilizing best practice criteria for care coordination. The work of care coordination is divided between the physician and other members of the care coordination team; therefore, the following distribution of work in an optimally-functioning practice is as follows:

20% Physician
30% Care Coordinator
20% Health Coach
30% Office/Clerical

The fee-for-service rate for one hour of care coordination was calculated after discounting for the above work distribution over time (Care Coordinator and Health Coach are at 65% of the physician rate and office/clerical are at 30%).

The agencies rates were set as of July 1, 2012 and are effective for services on or after that date. All rates are published on the agency website: www.ime.state.ia.us/Reports_Publications/FeeSchedule.html. The State fully intends to evaluate set rates annually to ensure they are reasonable and appropriate for the services they purchase.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Quality/Outcome Measurement Incentive Calculation

All Health Home Providers will report annually Quality/Outcome Measurements to the State and are eligible to receive incentive payments for achieving quality/performance benchmarks. No monetary value will be tied to performance measures in the first measurement year, (7/1/2012 - 6/30/2013). Beginning July 1, 2013, performance payments will be paid lump sum annually based on achieving quality/performance benchmarks. The quality/outcome measures are separated into five categories: 1) Preventive Measures; 2) Diabetes Measures; 3) Hypertension Measure; and 4) Mental Health Measure; and 5) Total Cost of Care. Each category is weighted based on importance and attainability of the measures. Payment will be made by September 30, following the end of the performance year.

The quality/outcome measurement incentive payment is equal to a percentage of the PMPM payments that are made to each participating health home. The maximum amount of incentive payment that a health home can attain is twenty (20) percent of the total PMPM payments made to that participating Health Home. The total PMPM payments is the sum of all Patient Management Payments made to the participating Health Home for patients attributed to the provider during the performance year.

The quality/outcome measurement incentive payment is contingent on a participating Health Home provider's performance on the quality/outcome measures specified for the categories below. Each category is worth a percentage of the maximum incentive payment amount. Within each category, the specified minimum performance must be achieved for each measure in order to receive the category's percent value; if performance is not achieved, on any of the required measures, the category's value is zero (0). The weight for each category achieved is then applied as a percentage of the maximum incentive payment amount.

The State will inform Health Home providers prior to the start of each performance year the target performance (also known as the minimum performance or benchmark) for each measure. The Health Home Provider must achieve the target performance for each measure in the category to achieve the bonus for that category.

Formula:

20% of Patient Management Payments for Measurement Year = Maximum Incentive Payment (MIP)
Category 1 Assigned Value = 35% of MIP
Category 2 Assigned Value = 30% of MIP
Category 3 Assigned Value = 20% of MIP
Category 4 Assigned Value = 15% of MIP

Category: Preventive Measures (best two out of three measures count for the practice)
Assigned Value of bonus = 35% Source = Health Information Network

Children turning 2 years old in reporting year who receive 4 DtaP, 3 IPV, 1 MMR, 4 HIB, 3 HEP-B, 1 VZV and 4 pneumococcal conjugate vaccines on or before their second birthday.

Flu shots for adults ages > 6 months
Document BMI and appropriate follow-up planning when needed.

Category: Disease Option 1 (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus = 30% Source = Health Information Network

Diabetes Management:

- Dilated eye exam (annual by optometrist or ophthalmologist)
- Micro albumin (annual)
- Foot exam (annual)
- Proportion with HgA1c less than 8
- Proportion with LDL less than 100

Asthma Management

- Asthma Patients with Asthma-related Emergency Room Visit
- Use of appropriate medications for people with asthma
- Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen

Category: Disease Option2 (Health Home picks the measure that most aligns with the practice population)
Assigned value of bonus = 20% Source = Health Information Network

Proportion with blood pressure less than 140 systolic and less than 90 diastolic; blood pressure check each visit.

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Effective: 7-1-12 Approved: 6-7-12

Systemic Antimicrobials

Category: Mental Health Measure (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus 15% Source = Health Information Network

Percentage of discharges for members 6 years of age and older who were hospitalized for treatment selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
Clinical Depression Screening

Category: Total Cost of Care
Assigned Value of Bonus = 0% Source = Health Information Network

Total cost of care per member/per year Reporting Only The state envisions this measures being tied to monetary bonus in the future, once the baseline has been established. This measure will begin for reporting purposes only to introduce the calculation to health home providers.

Health Home providers are measured during the twelve month reporting period using the measures described above for only those Health Home patients that were enrolled at start of the reporting period and that received at least two months of patient management payments during the reporting period.

☒ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

none

Description

none

☐ Tiered?

Continuation of Medicaid Payments Established by Section 1202 of the Affordable Care Act (Increased Primary Care Service Payment 42 CFR 447.400, 447.405, 447.410)

Attachment 4.19-B: Physician Services Amount of Minimum Payment

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 CFR 447.400, 447.405 and 447.410 remain in effect. The rates will be those in effect for these payments as of January 1, 2014.

☒ The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99339, 99340, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99403, 99404, 99406, 99411, 99412, 99429

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460 (Effective 01.01.11), 90461 (Effective 01.01.11), 99224 (01.01.11), 99225 (01.01.11), 99226 (01.01.11), 99441 (10.01.10), 99442 (10.01.10), 99443 (10.01.10), 99444 (10.01.10), 99499 (10.01.10)

Physician Services – Vaccine Administration

The state reimburses vaccine administration services furnished by the physicians identified above at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the rate established in accordance with 42 CFR 444.405(b)(2) as of January 1, 2014.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered January 1, 2015 through June 30, 2017.

Vaccine Administration

This reimbursement methodology applies to services delivered January 1, 2015 through June 30, 2017.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness). The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date. All rates are published at <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule/agreement>

Reserved